		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005397

Facility Name: LaMoine Christian Nursing Home

Address: 145 South Chamberlain - Box 770 (Number) Roseville (City) 61473-0770 (Zip Code)

County: Warren

Telephone Number: 309-462-2134 **Fax #** ( )

IDPA ID Number: 37-08415692003

Date of Initial License for Current Owners: 09/01/1970

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2003 to June 30, 2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Richard A. Walbert
(Title) Vice President of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,669	2,152	2,618	11,439	8
9	SNF/PED					9
10	ICF	7,763	7,793		15,556	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,432	9,945	2,618	26,995	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.71%

D. How many bed-hold days during this year were paid by Public Aid?
84 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 99 and days of care provided 2,618

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	116,669	12,401	5,496	134,566		134,566		134,566			1
2	Food Purchase		133,272		133,272		133,272	(153)	133,119			2
3	Housekeeping	113,154	18,085		131,239		131,239		131,239			3
4	Laundry											4
5	Heat and Other Utilities			73,097	73,097		73,097	5,447	78,544			5
6	Maintenance	30,258	8,613	14,297	53,168		53,168	5,919	59,087			6
7	Other (specify):*											7
8	**TOTAL General Services**	260,081	172,371	92,890	525,342		525,342	11,213	536,555			8
	B. Health Care and Programs											
9	Medical Director			1,000	1,000		1,000		1,000			9
10	Nursing and Medical Records	881,643	98,945	615	981,203		981,203		981,203			10
10a	Therapy			167,679	167,679		167,679		167,679			10a
11	Activities	26,775			26,775		26,775		26,775			11
12	Social Services	57,380	873	3,877	62,130		62,130		62,130			12
13	Nurse Aide Training											13
14	Program Transportation			881	881		881	(881)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	965,798	99,818	174,052	1,239,668		1,239,668	(881)	1,238,787			16
	C. General Administration											
17	Administrative	98,783	443	163,320	262,546		262,546	(123,142)	139,404			17
18	Directors Fees											18
19	Professional Services			3,513	3,513		3,513	4,811	8,324			19
20	Dues, Fees, Subscriptions & Promotions			26,462	26,462		26,462	(14,352)	12,110			20
21	Clerical & General Office Expenses	70,788	5,960	64,787	141,535		141,535	72,643	214,178			21
22	Employee Benefits & Payroll Taxes			264,354	264,354		264,354	15,650	280,004			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,635	9,635		9,635	6,564	16,199			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,741	100,741		100,741	635	101,376			26
27	Other (specify):*											27
28	**TOTAL General Administration**	169,571	6,403	632,812	808,786		808,786	(37,191)	771,595			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,395,450	278,592	899,754	2,573,796		2,573,796	(26,859)	2,546,937			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LaMoine Christian Nursing Home #0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			94,635	94,635		94,635	19,075	113,710			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			233	233		233		233			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			94,868	94,868		94,868	19,075	113,943			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			32,156	32,156		32,156		32,156			39
40	Barber and Beauty Shops	16,548	261		16,809		16,809		16,809			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	16,548	261	86,508	103,317		103,317		103,317			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,411,998	278,853	1,081,130	2,771,981		2,771,981	(7,784)	2,764,197			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(153)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,513	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(6,705)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,707)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	31,779	21		24
25	Fund Raising, Advertising and Promotional	(1,751)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(12,733)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 15,243		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,027)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (23,027)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (7,784)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LaMoine Christian Nursing Home

ID# 0005397

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous	$ 10	17	1
2	Vending	3	21	2
3	Activity	172	21	3
4	Transportation	(881)	14	4
5	Loss on Disposal	564	21	5
6	Marketing Expense	(12,601)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(12,733)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(153)	0	0	0	0	0	0	0	0	0	0	(153)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	5,447	0	0	0	0	0	0	0	0	0	5,447	5
6	Maintenance	0	5,919	0	0	0	0	0	0	0	0	0	5,919	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(153)	11,366	0	0	0	0	0	0	0	0	0	11,213	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(881)	0	0	0	0	0	0	0	0	0	0	(881)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(881)	0	0	0	0	0	0	0	0	0	0	(881)	16
	C. General Administration													
17	Administrative	10	(123,152)	0	0	0	0	0	0	0	0	0	(123,142)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,811	0	0	0	0	0	0	0	0	0	4,811	19
20	Fees, Subscriptions & Promotions	(14,352)	0	0	0	0	0	0	0	0	0	0	(14,352)	20
21	Clerical & General Office Expenses	21,106	51,537	0	0	0	0	0	0	0	0	0	72,643	21
22	Employee Benefits & Payroll Taxes	0	15,650	0	0	0	0	0	0	0	0	0	15,650	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,564	0	0	0	0	0	0	0	0	0	6,564	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	635	0	0	0	0	0	0	0	0	0	635	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	6,764	(43,955)	0	0	0	0	0	0	0	0	0	(37,191)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	5,730	(32,589)	0	0	0	0	0	0	0	0	0	(26,859)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **LaMoine Christian Nursing Home** **#** **0005397** **Report Period Beginning:** **July 1, 2003** **Ending:** **June 30, 2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,513	9,562	0	0	0	0	0	0	0	0	0	19,075	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,513	9,562	0	0	0	0	0	0	0	0	0	19,075	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	15,243	(23,027)	0	0	0	0	0	0	0	0	0	(7,784)	45

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc	100.00%	$ 5,447	$ 5,447	1
2	V	6	Maintenance				5,919	5,919	2
3	V	17	Administrative	163,320			40,168	(123,152)	3
4	V	19	Professional Services				4,811	4,811	4
5	V	21	Clerical				51,537	51,537	5
6	V	22	Employee Benefits				15,650	15,650	6
7	V	24	Travel & Seminar				6,564	6,564	7
8	V	26	Insurance				635	635	8
9	V	30	Depreciation				9,562	9,562	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 163,320			$ 140,293	$ * (23,027)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: ne 30, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	This workpaper is not applicable.											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaMoine Christian Nursing Home COUNTY Warren

FACILITY IDPH LICENSE NUMBER 0005397

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	7-050-086-00	7-346 S31 T9 R2	$ 80.40	$
2.	7-050-092-00	7-349 S31 T9 R2	$ 74.48	$
3.	7-050-087-00	7-347 S31 T9 R2	$ 74.48	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 229.36	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,150 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	1,360,680	1968	$ 10,992	1
2	Home Office Allocation			4,138	2
3	TOTALS	1,360,680		$ 15,130	3

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		1971	1971	$ 828,269	$ 16,565	40	$ 20,707	$ 4,142	$ 542,618	4
5	37		1975	1975	574,166	11,483	36	15,949	4,466	338,764	5
6			1976	1976	29,531	591	20	1,477	886	16,843	6
7											7
8	Home Office Allocation				32,923	954		954		16,030	8
	Improvement Type**										
9	Building Improvements			1977	2,335	52	33	71	19	1,365	9
10	Windows			1980	8,654	192	45	192		4,654	10
11	Windows			1980	8,415	191	44	191		4,489	11
12	Remodeling			1981	341	8	44	8		184	12
13	Remodeling			1981	2,643	60	44	60		1,384	13
14	Heating Systems			1982	50,515		20			50,515	14
15	Garage			1982	9,457	378	25	378		8,348	15
16	Furnace			1983	5,889	9	20	9		5,889	16
17	Building Improvements			1983	5,309	123	43	123		2,624	17
18	Office Remodel			1986	13,549	339	40	339		6,074	18
19	Ventilating Fan			1987	463		10			463	19
20	Floor Tile			1988	2,089		5			2,089	20
21	Blank										21
22	Door Monitor			1989	1,170	39	15	39		1,170	22
23	Remodeling			1989	2,901	145	20	145		2,235	23
24	Door Monitor			1989	2,218		10			2,218	24
25	E W SGL Door Monitor			1989	1,057	70	15	70		1,044	25
26	Fire Alarm System			1990	16,365	818	20	818		11,793	26
27	Conventional Oven			1991	2,510	167	15	167		2,324	27
28	Light Fixtures			1991	395		10			395	28
29	Compressor			1992	1,126		10			1,126	29
30	Phone System			1992	623		10			623	30
31	Cubicle Track			1992	2,888		10			2,888	31
32	Hot Water System			1993	13,270	885	15	885		10,030	32
33	Remodeling			1993	5,233		5			5,233	33
34	Wallcoverings/carpet			1994	3,744		5			3,744	34
35	TV Antennae			1994	4,351	83	10	83		4,040	35
36	Flourscent Light Fixtures			1994	608		5			608	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Wallcoverings	1995	$ 1,445	$	5	$	$	$ 1,445	37
38	Remodel 4 rooms	1995	2,862		5			2,862	38
39	Wallpaper	1995	600		5			600	39
40	Flourscent Light Fixtures	1995	908	91	10	91		804	40
41	Egress Locking System	1995	3,252		5			3,252	41
42	Floorcoverings	1995	3,856		5			3,856	42
43	Wallpaper	1995	3,821		5			3,821	43
44	Roof	1996	168,868	11,258	15	11,258		90,064	44
45	Roof Exhaustor	1996	750		5			750	45
46	3 foot Bathroom fixtures	1996	935		5			935	46
47	Wallcoverings	1996	874		5			874	47
48	Vinyl-S Wing Wallway	1996	3,012		5			3,012	48
49	Wallcoverings - 5 rooms	1996	2,946		5			2,946	49
50	Sewer/Garbage Disposal	1996	3,058		5			3,058	50
51	Ceiling Tile Laundry	1997	1,237	124	10	124		858	51
52	Water Softner System	1997	10,033		5			10,033	52
53	Energy Management System	1997	14,830	1,483	10	1,483		9,887	53
54	Replumb end of N H	1997	14,103	1,410	10	1,410		9,282	54
55	Wallcoverings	1997	985		5			985	55
56	Dining Room Windows	1997	6,533	653	10	653		4,299	56
57	Remodel Bathroom	1997	2,229		5			2,229	57
58	Remodel Office	1998	1,696		5			1,696	58
59	Wallpaper Restroom	1998	3,003		5			3,003	59
60	Carpet-Lobby	1999	2,566	129	5	129		2,566	60
61	Wallpaper-Hallways	1999	14,431	1,204	5	1,204		14,431	61
62	Motherboards-Fire Alarm	1999	1,385	138	5	138		1,385	62
63	Wallpaper-Restrooms	1999	5,733	1,145	5	1,145		5,733	63
64	Door Locking System	1999	9,490	1,582	5	1,582		9,490	64
65	Windows-Dining Room	1999	7,640	509	15	509		2,672	65
66	Serving Lamps	2000	1,470	294	5	294		1,446	66
67	Entrance Canopy w/Sidewalk	2000	3,577	358	10	358		1,760	67
68	Wallpaper	2000	1,164	233	5	233		1,068	68
69	Wallpaper	2000	5,430	1,086	5	1,086		4,616	69
70	TOTAL (lines 4 thru 69)		$ 1,937,729	$ 54,849		$ 64,362	$ 9,513	$ 1,257,522	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,937,729	$ 54,849		$ 64,362	$ 9,513	$ 1,257,522	1
2	Light Fixtures	2000	1,039	104	10	104		425	2
3	Seagull Fixture	2000	5,631	563	10	563		2,299	3
4	Deluxe Composite Stool	2000	1,404	140	10	140		572	4
5	Sink (North Port-R Med)	2000	908	91	10	91		440	5
6	Seagull Fixture (8)	2000	856	86	10	86		351	6
7	Floor Base	2000	614	123	5	123		492	7
8	Top Treatment (2)	2000	620	124	5	124		496	8
9	ZONELINE HEAT/ COOL	2000	7,218	481	15	481		1,924	9
10	DOUBLE SWING (51)	2000	1,595	319	5	319		1,276	10
11	ZONELINE HEAT/ COOL (11)	2000	7,476	498	15	498		1,909	11
12	MATTRESS (6)	2000	775	97	8	97		372	12
13	INSTALLATION OF ALK IN FREEZER	2000	9,498	950	10	950		3,721	13
14	FURNACE HEAT EXCHANGER	2000	1,448	290	5	290		1,039	14
15	WALLPAPERING SOUTH WING	2001	2,447	489	5	489		1,712	15
16	ENLARGE/REMODEL P.T. ROOM	2001	5,826	583	10	583		2,041	16
17	CABINETS	2001	574	38	15	38		127	17
18	WALK-IN COOLER (DOWN PAYMENT)	2001	5,000	500	10	500		1,625	18
19	10 Store Room Locks	2001	501	100	5	100		300	19
20	WALK-IN COOLER (Final PAYMENT)	2001	4,598	460	10	460		1,380	20
21	Replacement of Broken Window	2001	625	42	15	42		119	21
22	Interiors Decorations/Nursing Home	2001	506	101	5	101		295	22
23	Carpet - South Wing	2001	9,810	1,962	5	1,962		5,232	23
24	Heat Exchanger	2001	1,598	107	15	107		285	24
25	Remodeling Project/RR #302,303,305	2002	5,228	523	10	523		1,220	25
26	Kitchen Remodeling/Sink,Counter tops, shelves	2002	2,608	174	15	174		406	26
27	Remodeling Project/Staff Lounge,Beauty Shop	2002	20,771	2,077	10	2,077		4,673	27
28	Remodel Men's Public Restroom	7/19/2002	1,469	147	10	147		294	28
29	Install New Water Line to Dining Room	10/28/2002	1,780	89	20	89		156	29
30	Wanderguard Monitor & Auxiliary Monitor	2/5/2003	821	55	15	55		78	30
31	Rooftop AC unit	5/8/2003	15,680	1,568	10	1,568		1,829	31
32	Install 220V Outlet in Dining Room	5/15/2003	572	29	5	29		34	32
33	Emergency Circuits for Cooler & Freezer	8/7/2003	1,442	66	20	66		66	33
34	TOTAL (lines 1 thru 33)		$ 2,058,667	$ 67,825		$ 77,338	$ 9,513	$ 1,294,710	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,058,667	$ 67,825		$ 77,338	$ 9,513	$ 1,294,710	1
2	(2) Red Oak Doors - South Wing	10/27/2003	1,815	91	15	91		91	2
3	(3) Core Oak Wood Doors - South Wing	10/27/2003	1,214	61	15	61		61	3
4	Soffit in Kitchen	12/4/2003	2,050	80	15	80		80	4
5	Install New Plumbing in Kitchen	11/13/2003	2,554	149	10	149		149	5
6	(2) Nurses Station	4/1/2004	3,500	88	10	88		88	6
7	Water Heater	5/27/2004	1,369	23	10	23		23	7
8	Replace Tile Floor in Day Room	6/29/2004	2,900	24	10	24		24	8
9	Fully depreciated land improvements	6/30/1974	9,358		20			9,358	9
10	Water and sewer work	6/16/1987	20,638	988	20	988		17,601	10
11	Trees & shrubs	5/23/1991	1,315	66	20	66		869	11
12	Parking lot	6/30/1995	15,426	1,543	10	1,543		14,016	12
13	Resurface lot	9/8/1999	3,500		3			3,500	13
14	Landscaping and sign	6/1/2000	6,235	624	10	624		2,387	14
15	Gazebo and landscaping	6/4/2001	4,189	419	10	419		1,280	15
16	Sign	2/5/2002	580	58	10	58		140	16
17	Yard barn	9/30/1993	500		5			500	17
18	Bus barn	10/24/1995	12,815	641	20	641		4,915	18
19	Overhead door opener	6/3/2002	726	73	10	73		152	19
20	Memorial Garden-Concrete Table/Patio	8/7/2003	2,639	161	15	161		161	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28	Less: Disposals		(3,703)					(3,392)	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,148,287	$ 72,914		$ 82,427	$ 9,513	$ 1,346,713	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 168,404	$ 21,918	$ 21,918	$	Various	$ 91,064	71
72	Current Year Purchases	25,277	757	757		Various	757	72
73	Fully Depreciated Assets	200,599				Various	200,599	73
74	Home Office Allocation	52,907	7,044	7,044			23,900	74
75	TOTALS	$ 447,187	$ 29,719	$ 29,719	$		$ 316,320	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1979 GMC Van	1979	$ 10,311	$	$	$	5	$ 10,311	76
77	Patient Transportation	1994 Ford Bus	1994	44,700				8	44,700	77
78										78
79	Home Office Allocation			6,421	1,564	1,564			3,915	79
80	TOTALS			$ 61,432	$ 1,564	$ 1,564	$		$ 58,926	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,672,036	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,197	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,710	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,513	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,721,959	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 79,603	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 79,603	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 37,543	92
93			93
94			94
95		$ 37,543	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 662,762	$	1
2	Cash-Patient Deposits	7,989		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,787)	278,906		3
4	Supply Inventory (priced at FIFO)	14,240		4
5	Short-Term Investments	382,686		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int/Other A/R	5,292		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,351,875	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	90,594		13
14	Buildings, at Historical Cost	2,051,481		14
15	Leasehold Improvements, at Historical Cost	63,878		15
16	Equipment, at Historical Cost	449,290		16
17	Accumulated Depreciation (book methods)	(1,678,114)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	416,507		21
22	Other Long-Term Assets (spe CIP	37,544		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,431,180	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,783,055	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,839	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,989		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,553		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	229		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 218,610	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 218,610	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,564,445	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,783,055	$	48

***(See instructions.)**

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,276,716	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,276,716	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	432,729	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 432,729	17
	B. Transfers (Itemize):		
18	**Transfer Out to Affiliate**	(145,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (145,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,564,445	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,164,595	1
2	Discounts and Allowances for all Levels	(410,897)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,753,698	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	276,510	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 276,510	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,948	13
14	Non-Patient Meals	153	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,963	19
20	Radiology and X-Ray	5,849	20
21	Other Medical Services	6,520	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 70,433	23
	D. Non-Operating Revenue		
24	Contributions	89,048	24
25	Interest and Other Investment Income***	25,552	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 114,600	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investments/Disposal of Equip	(10,531)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (10,531)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,204,710	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	525,342	31
32	Health Care	1,239,668	32
33	General Administration	808,786	33
	B. Capital Expense		
34	Ownership	94,868	34
	C. Ancillary Expense		
35	Special Cost Centers	48,965	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,771,981	40
41	**Income before Income Taxes (line 30 minus line 40)****	432,729	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 432,729	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,665	1,780	$ 45,378	$ 25.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,403	4,672	104,998	22.47	3
4	Licensed Practical Nurses	13,714	14,067	196,670	13.98	4
5	Nurse Aides & Orderlies	43,108	43,822	506,149	11.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,302	2,340	28,448	12.16	8
9	Activity Director	1,403	1,463	18,337	12.53	9
10	Activity Assistants	985	1,012	8,438	8.34	10
11	Social Service Workers	4,178	4,362	57,380	13.15	11
12	Dietician					12
13	Food Service Supervisor	1,737	1,796	22,057	12.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,565	10,822	94,612	8.74	15
16	Dishwashers					16
17	Maintenance Workers	2,298	2,340	30,258	12.93	17
18	Housekeepers	10,305	10,437	113,154	10.84	18
19	Laundry					19
20	Administrator	1,694	2,015	98,783	49.02	20
21	Assistant Administrator					21
22	Other Administrative	1,607	1,702	29,654	17.42	22
23	Office Manager	1,643	1,716	22,654	13.20	23
24	Clerical	1,073	1,132	18,480	16.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,289	1,298	16,548	12.75	33
34	TOTAL (lines 1 - 33)	103,969	106,776	$ 1,411,998 *	$ 13.22	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	126	$ 5,496	3.1	35
36	Medical Director	156	1,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,203	56,721	10A.3	40
41	Occupational Therapy Consultant	1,186	52,663	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	217	9,433	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	39	3,356	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,927	$ 128,669		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Gutermuth	Administrator	100%	$ 98,783
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,783

B. Administrative - Other

Description	Amount
Management Fee	$ 163,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 163,320
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Melotte-Morse	Architect	$ 595
Ideal Nursing Home Inc	Consulting	1,251
Van Ostrand	Legal	742
Davis & Campbell	Legal	475
Miscellaneous	Miscellaneous	50
P K Bhosale	Architect	400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,513

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,180
Unemployment Compensation Insurance	9,900
FICA Taxes	103,974
Employee Health Insurance	106,800
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniforms	624
Employee Physicals	812
Employee Expense	6,064
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,004

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 750
Advertising: Employee Recruitment	652
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	3,512
Software/Hardware Support/fees	5,882
Dues	1,027
Miscellaneous fees	287
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,110

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 176
In-State Travel	3,908
Miscellaneous	2,046
Seminar Expense	3,505
Home Office Allocation	6,564
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,199

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LaMoine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2003 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $3512**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,250** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **153**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ None

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

LaMoine Christian
Allocation on Benefits 6/30/2004 sms
10/25/2004

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	W C Med Expense	Employee Uniforms	Employee Expense	Employee Physicals		
11,631.92	372.00	1,368.00	3,600.00		623.82	6064.51	812.10	24,472.35	
249.70	204.00	744.00	16,400.00					17,597.70	
1,757.28	1,200.00	4,368.00	77,200.00					84,525.28	
9,331.86	960.00	3,492.00	9,600.00					23,383.86	
8,229.39	6,384.00	23,352.00						37,965.39	
65,966.52	684.00	2,520.00						69,170.52	
5,550.83	96.00	336.00						5,982.83	
1,256.44								1,256.44	264,354.37
103,973.94	9,900.00	36,180.00	106,800.00	0	623.82	6064.51	812.10	264,354.37	

Line 3.22.3 264,354.37

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LaMoine Christian Nursing Home
Staffiing and Salary Costs

sms
06/30/04 11/03/05

Description	Line Number	Salary	% of Benefits	Benefits	Total Salary	LMCV
Director of Nursing	20.1	43,331.64	5.15%	2,046.29	45,377.93	
Assist. DON	20.2	0.00	0.00%	0.00	0.00	
Registered Nurses	20.3	100,262.87	11.91%	4,734.80	104,997.67	
Licensed Practical Nurses	20.4	187,801.38	22.31%	8,868.70	196,670.08	
Nurses Aides & Orderlies	20.5	483,325.04	57.41%	22,824.45	506,149.49	
Rehab/Therapy Aides	20.8	27,165.12	3.23%	1,282.84	28,447.96	
	Total	841,886.05	100.00%	39,757.07	881,643.12	

	Benefits	39,757.07					
	20.1	20.2	20.3	20.4	20.5	20.8	
	43,331.64		10,301.01	3,478.30	10,583.71	27,165.12	
			7,375.01	96,654.92	4,926.18		
			56,712.50	56,772.76	28,579.32		
			11,547.21	13,864.08	292,336.23		
			14,059.85	15,901.82	89,139.91		
			267.29	90.75	11,039.93		
				1,038.75	3,002.38		
					41,585.02		
					1,682.47		
					449.89		
Totals	43,331.64	0.00	100,262.87	187,801.38	483,325.04	27,165.12	

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